Complete Summary

GUIDELINE TITLE

Standards of medical care in diabetes. IV. Prevention/delay of type 2 diabetes.

BIBLIOGRAPHIC SOURCE(S)

American Diabetes Association (ADA). Standards of medical care in diabetes. IV. Prevention/delay of type 2 diabetes. Diabetes Care 2006 Jan;29(Suppl 1):S7-8.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Standards of medical care in diabetes. IV. Prevention/delay of type 2 diabetes. Diabetes Care 2005 Jan;28(suppl 1):S7-8.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Type 2 diabetes mellitus
- Pre-diabetes (impaired fasting glucose [IFG] or impaired glucose tolerance [IGT])

GUIDELINE CATEGORY

Prevention

CLINICAL SPECIALTY

Endocrinology
Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To discuss approaches to and provide recommendations for the prevention of type 2 diabetes
- To provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, treatment goals, and tools to evaluate the quality of care

TARGET POPULATION

Individuals with risk factors for developing type 2 diabetes mellitus

INTERVENTIONS AND PRACTICES CONSIDERED

Prevention

1. Lifestyle modification (weight loss, physical activity) and counseling
2. Provision of follow-up counseling
3. Monitoring at regular intervals
4. Treatment for other cardiovascular risk factors including tobacco use, hypertension, and dyslipidemia
5. Drug therapy (considered, but not routinely recommended)

MAJOR OUTCOMES CONSIDERED

- Glucose levels
- Incidence of diabetes following lifestyle interventions and/or drug therapy
- Weight loss

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

American Diabetes Association's Evidence Grading System for Clinical Practice Recommendations

A

Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including:

- Evidence from a well-conducted multicenter trial
- Evidence from a meta-analysis that incorporated quality ratings in the analysis
- Compelling non-experimental evidence (i.e., "all or none" rule developed by the Center for Evidence Based Medicine at Oxford*)

Supportive evidence from well-conducted randomized, controlled trials that are adequately powered, including:

- Evidence from a well-conducted trial at one or more institutions
- Evidence from a meta-analysis that incorporated quality ratings in the analysis

*Either all patients died before therapy and at least some survived with therapy, or some patients died without therapy and none died with therapy. Example: use of insulin in the treatment of diabetic ketoacidosis.

B

Supportive evidence from well-conducted cohort studies, including:

- Evidence from a well-conducted prospective cohort study or registry
- Evidence from a well-conducted meta-analysis of cohort studies

Supportive evidence from a well-conducted case-control study

C

Supportive evidence from poorly controlled or uncontrolled studies, including:

- Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results
- Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)
- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations have been assigned ratings of A, B or C, depending on the quality of evidence (see "Rating Scheme for the Strength of the Evidence"). Expert opinion (E) is a separate category for recommendations in which there is as yet no evidence from clinical trials, in which clinical trials may be impractical, or in which there is conflicting evidence. Recommendations with an "A" rating are based on large, well-designed clinical trials or well done meta-analyses. Generally, these recommendations have the best chance of improving outcomes when applied to the population to which they are appropriate. Recommendations with lower levels of evidence may be equally important but are not as well supported.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The recommendations were reviewed and approved in October 2005 by the Professional Practice Committee and, subsequently, by the Executive Committee of the Board of Directors.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The evidence grading system (A-C, E) is defined at the end of the "Major Recommendations" field.

Prevention/Delay of Type 2 Diabetes

- Individuals at high risk for developing diabetes need to become aware of the benefits of modest weight loss and participating in regular physical activity. (A)
- Patients with impaired glucose tolerance (IGT) should be given counseling on weight loss as well as instruction for increasing physical activity. (A)
- Patients with impaired fasting glucose (IFG) should be given counseling on weight loss as well as instruction for increasing physical activity. (E)
- Follow-up counseling appears important for success. (B)
- Monitoring for the development of diabetes in those with pre-diabetes should be performed every 1 to 2 years. (E)
- Close attention should be given to, and appropriate treatment given for, other cardiovascular disease (CVD) risk factors (e.g., tobacco use, hypertension, dyslipidemia). (A)
- Drug therapy should not be routinely used to prevent diabetes until more information is known about its cost effectiveness. (E)

Definitions:

American Diabetes Association's Evidence Grading System for Clinical Practice Recommendations

A

Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including:

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*Either all patients died before therapy and at least some survived with therapy, or some patients died without therapy and none died with therapy. Example: use of insulin in the treatment of diabetic ketoacidosis.

B

Supportive evidence from well-conducted cohort studies:

- Evidence from a well-conducted prospective cohort study or registry
- Evidence from a well-conducted prospective cohort study
- Evidence from a well-conducted meta-analysis of cohort studies

Supportive evidence from a well-conducted case-control study

C

Supportive evidence from poorly controlled or uncontrolled studies, including:

- Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results
- Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)
- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Current knowledge of the early stages of hyperglycemia that portend the diagnosis of diabetes, and the recent success of major intervention trials, clearly show that individuals at high risk can be identified and diabetes delayed, if not prevented. The cost-effectiveness of intervention strategies is unclear, but the huge burden resulting from the complications of diabetes and the potential ancillary benefits of some of the interventions suggest that an effort to prevent diabetes is worthwhile.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Evidence is only one component of decision-making. Clinicians care for patients, not populations; guidelines must always be interpreted with the needs of the individual patient in mind. Individual circumstances such as comorbid and coexisting diseases, age, education, disability, and, above all, patient's values and preferences must also be considered and may lead to different treatment targets and strategies. Also, conventional evidence hierarchies such as the one adapted by the American Diabetes Association may miss some nuances that are important in diabetes care.
- While individual preferences, comorbidities, and other patient factors may require modification of goals, targets that are desirable for most patients with diabetes are provided. These standards are not intended to preclude more extensive evaluation and management of the patient by other specialists as needed.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

In recent years, numerous health care organizations, ranging from large health care systems such as the U.S. Veteran's Administration to small private practices have implemented strategies to improve diabetes care. Successful programs have published results showing improvement in important outcomes such as A1C measurements and blood pressure and lipid determinations as well as process measures such as provision of eye exams. Successful interventions have been focused at the level of health care professionals, delivery systems, and patients. Features of successful programs reported in the literature include:

- Improving health care professional education regarding the standards of care through formal and informal education programs.

- Delivery of diabetes self-management education (DSME), which has been shown to increase adherence to standard of care.
- Adoption of practice guidelines, with participation of health care professionals in the process. Guidelines should be readily accessible at the point of service, such as on patient charts, in examining rooms, in "wallet or pocket cards," on personal digital assistants (PDAs), or on office computer systems. Guidelines should begin with a summary of their major recommendations instructing health care professionals what to do and how to do it.
- Use of checklists that mirror guidelines have been successful at improving adherence to standards of care.
- System changes, such as provision of automated reminders to health care professionals and patients, reporting of process and outcome data to providers, and especially identification of patients at risk because of failure to achieve target values or a lack of reported values.
- Quality improvement programs combining continuous quality improvement or other cycles of analysis and intervention with provider performance data.
- Practice changes, such as clustering of dedicated diabetes visits into specific times within a primary care practice schedule and/or visits with multiple health care professionals on a single day and group visits.
- Tracking systems either with an electronic medical record or patient registry have been helpful at increasing adherence to standards of care by prospectively identifying those requiring assessments and/or treatment modifications. They likely could have greater efficacy if they suggested specific therapeutic interventions to be considered for a particular patient at a particular point in time.
- A variety of non-automated systems, such as mailing reminders to patients, chart stickers, and flow sheets, have been useful to prompt both providers and patients.
- Availability of case or (preferably) care management services, usually by a nurse. Nurses, pharmacists, and other non-physician health care professionals using detailed algorithms working under the supervision of physicians and/or nurse education calls have also been helpful. Similarly dietitians using medical nutrition therapy (MNT) guidelines have been demonstrated to improve glycemic control.
- Availability and involvement of expert consultants, such as endocrinologists and diabetes educators.

Evidence suggests that these individual initiatives work best when provided as components of a multifactorial intervention. Therefore, it is difficult to assess the contribution of each component; however, it is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of health care professionals.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Jan (revised 2006 Jan)

GUIDELINE DEVELOPER(S)

American Diabetes Association - Professional Association

SOURCE(S) OF FUNDING

The American Diabetes Association (ADA) received an unrestricted educational grant from LifeScan, Inc., a Johnson and Johnson Company, to support publication of the 2006 Diabetes Care Supplement.

GUIDELINE COMMITTEE

Professional Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Vivian Fonseca, MD, Chair; Evan M. Benjamin, MD; Lawrence Blonde, MD; Kenneth Copeland, MD; Marjorie L. Cypress, MS, RN, CDE; Hertzel C. Gerstein, MD, Msc, FRCPC; Irl Hirsch, MD; Steven Kahn, MB, ChB; Elizabeth Mayer-Davis, MS, PhD, RD; James Meigs, MD, MPH; Michael P. Pignone, MD, MPH; Janet H. Silverstein, MD; Geralyn R. Spollett, MSN, C-ANP, CDE; Judith Wylie-Rossett, RD, EdD; Nathaniel G. Clark, MD, MS, RD, Staff

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Introduction. Diabetes Care 29:S1-S2, 2006
- Strategies for improving diabetes care. Diabetes Care 29:S34-S35, 2006.

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

The following is also available:

- 2006 clinical practice recommendations standards of care. Personal digital assistant (PDA) download. Available from the American Diabetes Association (ADA) Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on July 29, 2003. The summary was updated by ECRI on March 23, 2004, on July 1, 2005, and on March 16, 2006.

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